TRICARE Referral # _____

CONSENT & CHIEF COMPLAINT

Patient Name:_____ Date of Birth:_____/_____/ _____

(Minors) Name of Legal Parent/Guardian:_____ Cell Phone Number:(____) _____- _____

Chief Complaint: (Primary reason for your visit today) _____

Is this visit related to an Accident? [] No [] Yes **Date Occurred: ____/___/_____ Type: [**] Work Related [] Auto [] Other

Primary Care Physician First & Last Name:_____ Phone: (_____) _____- _____

Pharmacy Preferred Today:_____Location: _____

How did you hear about us?	[ ] Friend/Relative	[ ] Online	[ ] Billboard	[ ] T.V.
[ ] Magazine/Newspaper	[ ] Location	[ ] Physician Referral	[ ] Other:	

Consent for Treatment | Use of Protected Health Information | Financial Obligation

▪I hereby consent to medical evaluations, testing, and/or treatment provided by the staff of this medical facility. I understand that prior to treatments, procedures or receiving medications and vaccines I will be informed of the benefits, risk and possible side effects and allowed to ask questions for full knowledge to give informed consent. I understand that it is my responsibility to provide any information relevant to health history, possible medication interactions and allergies.

▪I acknowledge that I have reviewed the company Payment Policy and have been given the opportunity to ask questions and to have concerns and written request addressed. I hereby authorize the facility to accept assignment of contracted insurance benefits and I understand that I am responsible for co-insurance, co- payments, and/or deductibles at the time of service. I understand that if my insurance is a non-contracted plan (out-of-network), the facility will courtesy file the claim for services rendered and any monies received by the facility will be reimbursed to me. In the event that I have no insurance coverage, I understand that fees are due at the time of service. I understand that previous balances owed to the facility will be requested at time of registration and any outstanding balance will be billed with accrued interest. I understand that the facility may be contracted with specific Medicaid plans.
▪If my plan is not under contract with the facility, I may elect to accept sole responsibility for the payment of services, and the facility nor I may seek reimbursement from Medicaid for charges incurred. I understand that all fees are due at the time of service and prior to receiving discharge paperwork and/or prescriptions that complete the visit encounter.

▪I understand that if the provider has ordered additional laboratory test that the collected specimens will be sent to a local laboratory for testing. The facility will forward my payer information to the laboratory, but I will be responsible for the charges incurred for these services and will receive a separate bill from the laboratory. I understand that there may be a portion of the cost of Durable Medical Equipment that is not covered by my insurance company and I will be responsible for the balance.

▪I understand that the company may use or disclose my Protected Health Information (PHI) necessary to carry out treatment, payment, or healthcare operations or in other instances as permitted by HIPAA. For treatment purposes, the facility may request and utilize my medication history from other health care providers or third party pharmacy benefit payers. I hereby authorize the facility to e-prescribe my prescriptions.
▪I understand that the provider may use telemedicine and video technologies, and photographs of my injury or wound, etc. for treatment, consultation or specialist referrals. I understand that I may be referred to a health care provider for follow up care and that I will be given the freedom of choice in referral selection. If I do not have an established health care provider and have no preference in selection, I understand that my PHI may be sent to an affiliated health care organization to follow up with me to help coordinate my care. I understand that my insurance may not cover the services for which I am being referred and that I should verify coverage with that provider prior to my visit.

▪I understand that the contact information I provide such as my physical address, phone number and email may be used to send me patient satisfaction surveys, to provide me with information on health-related benefits and services that may be of interest to me and to provide me with marketing and fundraising material. I understand that I have the right to opt out or unsubscribe to any information or materials that I may receive.
▪I acknowledge that I was provided the Notice of Privacy Practices, the Notice of Nondiscrimination and the Patient Rights and Responsibilities. I have been allowed the opportunity to ask questions, to file a complaint for my concerns to be addressed, to submit a special written request and to object to the release of my PHI to a specific person if I so choose.

X_____ _____ **Date:**_____/_____/_____

Signature of Person Giving Consent **Relationship**
Patient/Guardian/Accompanying Adult